VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 3, 2012

Ms. Claudette Werner-Poorman, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201

Provider #: 475033

Dear Ms. Werner-Poorman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 11, 2012.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey 1/9/12 - 1/11/12. Regulatory deficiencies were cited as a result.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive plan of care for 1 of 3 residents (Resident #73) of the sample group after the resident developed a pressure ulcer. Findings include:	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Charlotte Wells Bowman Admr 1-31-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMK

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F 279	Continued From page 1 1. Per record review, Resident #73's Braden Scale (a scale used to determine the risk of developing a pressure ulcer, with >10 as high risk) upon admission and subsequent assessments is rated at 17. Per record review, Resident #73's Care Plan on 11/16/11 stated 'risk for impaired skin integrity related to limited mobility, incontinence.' Per record review, when Resident #73 developed a pressure ulcer on 11/28/11, h/her Care Plan was not revised to reflect an actual impairment in h/her skin integrity. Per record review, Resident #73's Treatment book: pressure ulcer assessment dated 11/28/11 states; Left heel 0.5 cm (centimeters) by 0.5 cm. Resident #73's Weekly Pressure Ulcer Record shows an increase in size of the pressure ulcer each week after 11/28/11, with the most recent on 1/4/12 recorded as 0.5 cm by 1.0 cm. Per interview with the facility's Minimum Data Sheet Coordinator [MDSC] on 1/11/12 at 11:30 A.M. it is the facility's policy that when a pressure ulcer is discovered an interim Care Plan specific for pressure ulcers is started. The pressure ulcer is assessed weekly, and the Care Plan is revised if there is a negative change. The MDSC confirmed that when Resident #73 developed a pressure ulcer, the interim Care Plan was not started, and it is h/her expectation that a Care Plan for Resident #73 would be developed with the increase in size of the pressure ulcer.	F 279	F279 Resident #73 remains in the facility in stable condition. Care Plan was updated to reflect impaired skin integrity. SDC will re-educated nursing staff to notify MDS and Nurse Manager of changes in skin integrity to ensure that care plan will be appropriately updated. MDS and Nurse Manager will create a form to monitor changes in skin integrity. Outcomes of monitoring and audits will be presented to the CQI Committee by MDS and Nurse Manager. Audits will be random and include all residents with risk for impaired skin integrity.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	F279 POC accepted 2/2/12 RTremblay RN MCotaRN	Feb 8, 2012

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F 280	Continued From page 2 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise the Care Plan for 1 of 3 residents in the sample group (Resident #18) after a significant weight loss. Findings include: 1. Per record review, Resident #18 underwent a significant weight loss of 6.2 pounds (loss of >5% of resident's weight within 30 days) between 12/12/11 and 1/8/12. Per interview with the facility's Minimum Data Sheet Coordinator (MDSC) on 1/11/12 at 11:30 A.M. h/she confirmed Resident #18's Intake and Output (I&O) were not monitored according to the Care Plan, and that Resident #18 was falling below the Care Plan goals. The MDSC stated it was h/her expectation that the Care Plan goals would be adjusted and the Care Plan modified with Resident #18's weight loss, and this was not	F 280	F280 Resident #18 remains in the facility in frail but stable condition. SDC will re-educate nurses the requirement of following facility policies related to weight loss per weight assessment policy. Random audits of all residents will be completed by SDC and Nurse Manager to assure compliance. Outcomes will be presented to CQI committee. F280 POC accepted 2/2/12 R. Tremblay RN/ Director RN	2/8/12

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F 280	Continued From page 3 done. The MDSC stated it is the facility's policy that when a severe/significant weight loss is recorded, the nurse recording it will fill out a weight loss form, a 3 day weight monitoring is initiated, and the resident's Doctor, resident's family, the MDSC, and the facility's Dietician would be notified. The resident's Doctor, Nurse, the MDSC and the Dietician then review the resident's Care Plan regarding the weight loss and revise the treatment and goals to reflect the resident's current condition/status. The MDSC confirmed after Resident #18's significant weight loss "there was no follow up", the facility's policies were not followed, and there was no review or revision to Resident #18's Care Plan regarding h/her severe weight loss. Refer also to F325.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that services were provided according to the resident's written plan of care regarding weight monitoring for 1 (Resident #105) of 3 applicable residents in the Stage 2 sample of 14 residents. Findings include: Per record review, the Nutrition care plan for	F 282		

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F 282	Continued From page 4 Resident #105 dated 09/13/2011 states "Weekly weights". Per review of facility policy, the Weight Assessment Monitoring Policy and Procedure states "Admissions are weighed within 48 hours of admission and then weekly for the first four weeks." The Resident Weekly Weight Record (hand written) and CORP Weight Report (computerized) for Resident #105 state that the resident was weighed on admission on 09/13/2011 as 156.6 pounds and the next weight recorded was on 10/18/2011 as 166.2 pounds. That weight reflects a 9.6 pound weight gain in 25 days. The policy states that for a weight gain or loss of 5 or more pounds, a weight is obtained by nursing and documented in Care Tracker: The next weight documented in Care Tracker is on 11/01/2011 when a weight of 167.3 pounds was recorded. In an interview on 01/10/2012 at 3:37 PM, the Unit Manager stated that weekly weights were not in the record. S/he further stated that the nutrition care plan called for continued weekly weights due to the weight gain reflected in the first two weights and that there is no evidence of weekly weights. On 11/16/2011 a weight of 168.6 pounds and on 12/07/2011 a weight of 174 pounds reflected an additional 5.4 pound weight gain. On 01/04/2012 a weight of 163 pounds was recorded. In an interview on 01/10/2012 at 4 PM, the Unit Manager stated that s/he was not made aware of the weight discrepancies. In an interview on 01/10/2012 the Registered Dietitian stated that s/he was not made aware of the weight change on 01/04/2012. Refer also to F325.	F 282	F282 Resident #105 remains in the facility in stable condition. SDC re-educated nursing staff on the importance of following facility weight protocol including obtaining weight, documentation and notification of appropriate parties. Audits of weight gain/loss will be completed randomly on all residents to assure compliance of policy by Nurse Mangers and Charge Nurses. Outcome of audits will be presented to the CQI Committee by Nurse Manager. F282 POC accepted 2/2/12 RTremblay RN/ PMasterni	2/6/12
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

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F 325 SS=D	Continued From page 5 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 2 residents (Resident #18 and #105) of the sample group maintained an acceptable parameter of nutritional status such as body weight, by failing to monitor the resident's Intake & Output, failing to monitor weights per the written care plan and facility policy, and failing to review and revise the resident's Plan of Care after a significant fluctuations in weight. Findings include: 1. Per record review Resident # 18 underwent a significant weight loss of 6.2 pounds (loss of greater than 5% of resident's weight within 30 days) between 12/12/11 and 1/8/12. Per record review, Resident #18's Minimum Data Set (MDS) on 11/7/11 indicates a "weight loss of 5% or more" with the resident "not on a weight loss program." Per record review, Resident #18's Care Plan dated 11/17/11 states: Nutrition: at risk related to variable PO (by mouth) intake of	F 325		

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F 325	Continued From page 6 50-100%. Intervention: maintain intake greater than 50% per meal. Per record review, Resident #18's Care Plan dated 11/17/11 states: Fluid Volume Deficit: related to variable PO intake. Interventions include; monitor Intake & Output (I&O), encourage PO intake to at least 1000-1500 milliliters fluid per 24 hours. Per staff interview with Resident #18's Unit Charge Nurse on 1/11/12 at 12:39 P.M., the nurses do not do daily I&O monitoring on the residents. If a resident is on I&O monitoring, the nurses do not have access to the I&O records but can request the Unit Manager to retrieve the information from the computer. The Charge Nurse confirmed that this has not been done for Resident #18 to monitor I&O. Per record review, Resident #18's daily I&O chart for 12/10/11 - 1/10/12 records that h/she did not meet the intake goal of greater than 50% per meal for 57% of the meals, and did not meet the fluid intake goal of 1000 - 1500 milliliters per 24 hours on 62% of the days. Per interview with the facility's Minimum Data Set Coordinator (MDSC) on 1/11/12 at 11:30 A.M. h/she confirmed Resident #18's I&O were not monitored according to the Care Plan, and that Resident #18 was falling below the Care Plan goals. The MDSC stated it was h/her expectation that the Care Plan goals would be adjusted and the Care Plan modified with Resident #18's weight loss, and this was not done. The MDSC stated it is the facility's policy that when a severe/significant weight loss is recorded, the nurse recording it will fill out a weight loss form, a 3 day weight monitoring is initiated, and the resident's Doctor, resident's family, the MDSC, and the facility's Dietician would be notified. The resident's Doctor, Nurse, the MDSC and the	F 325	F325 Residents # 18 & 105 remain in the facility in stable condition. SDC re-educated nursing staff on the importance of following facility weight protocol including obtaining weight, documentation and notification of appropriate parties. Audits of weight gain/loss will be completed randomly on all residents to assure compliance of policy by Nurse Mangers and Charge Nurses. Outcome of audits will be presented to the CQI Committee by Nurse Manager. F325 POC accepted 2/2/12 RTremblay RN/ PMcotaRN	2/8/12

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F 325	Continued From page 7 Dietician then review the resident's Care Plan regarding the weight loss and revise the treatment and goals to reflect the resident's current condition/status. The MDSC confirmed after Resident #18's significant weight loss "there was no follow up", the facility's policies were not followed, and there was no review or revision to Resident #18's Care Plan regarding h/her severe weight loss. 2. Per record review and interview, Resident #105 had significant fluctuations in weight that were not closely monitored or assessed per the facility's protocols. Per review of the facility policy "Weight Assessment Monitoring" states "per nursing protocol...Admissions are weighed within 48 hours; and then weekly for the first four weeks and then monthly." Resident #105's record reflects an admission weight of 156.6 pounds on 09/13/2011. In the handwritten Resident Weekly Weight Report, the first recorded weight (166.2 pounds) is dated on 10/18/2011, as well as in the CORP Weight Change Report (computerized record). The weight recorded on 10/18/2011 reflects a 9.6 pound (6.6% of resident's weight) gain over a 30 day period since admission. There was no evidence of the weekly weights after admission. Subsequent weights were recorded in the CORP Weight Change Report on 11/01/2011 (167.3 pounds), 11/16/2011 (168.6 pounds), and 12/07/2011 (174 pounds), all reflecting a continued weight gain. These weights reflect a weight gain of 17.4 pounds since admission. On 01/04/2012, the recorded weight was 163 pounds, indicating an 11 pound weight loss in less than 30 days, which is greater than 5% of the resident's body weight. In further review of the	F 325		

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F 325	Continued From page 8 record, the care plan for Nutrition dated 09/13/2011 contains an intervention to Weigh weekly. In an interview on 01/10/2012 at 3:27 PM, the Unit Manager confirmed that there were no other weights found in the record. S/he stated that the resident remained on weekly weights in response to the significant weight change noted on 10/18/2011. She further acknowledged that there was no evidence that the usual weekly weights post-admission, and the continued weekly weights had been completed. The facility weight policy further states that, "If a resident loses/gains 5 or more pounds since their last weight a re-weight is obtained by nursing within 48 hours and documented in Care Tracker. The RN or LPN reports any confirmed weight loss to the RD, Nurse Manager, MDS coordinator, physician and family. A 3 day re-weigh may be indicated and can be initiated by any of the above". The record reflects a 9.6 pound weight gain on 10/18/2011, a 5.4 pound weight gain on 12/07/2011, and an 11 pound weight loss on 01/04/2012. There is a fax form which contains the weight gain of 5.4 pounds on 12/07/2011 and a 3 day re-weigh on 12/09/2011, 12/10/2011 and 12/11/2011. The form is to be faxed to the MD and provided to the RD (Registered Dietician), the Unit Manager, and the MDS coordinator. In an interview on 01/10/2012 at 4 PM the Unit Manager stated that she was unaware of the re-weighs and that when notified of re-weighs she co-signs the re-weigh form. There were no co-signs by the Unit Manager on either form. In an interview with the RD on 01/10/2012 at 4:16 PM, she states that she was unaware of the weight loss change on 01/04/2012 and of the December 2011 re-weighs. There are no	F 325		

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F 325	Continued From page 9 revisions to the care plan, new MD orders or RD notes found in regards to the December 2011 re-weighs.	F 325		